

U.S. DEPARTMENT OF HOMELAND SECURITY U.S. Coast Guard CG-4899 (Rev. 06-04)		REPORT OF POTENTIAL THIRD PARTY LIABILITY	
INSTRUCTIONS: Complete all blocks to the best of your knowledge. If unknown or not applicable, leave blank. Mail original to Commandant (G-WRP-2).			
SECTION I - IDENTIFICATION OF INJURED PERSON			
A. NAME (Last, First and Middle Initial)		B. SSAN	C. RANK/RATE D. WORK TELEPHONE <input type="checkbox"/> FTS <input type="checkbox"/> COMM
E. HOME ADDRESS (Include zip code)		F. DATE OF BIRTH	G. HOME TELEPHONE
H. STATUS OF BENEFICIARY <input type="checkbox"/> ACTIVE DUTY <input type="checkbox"/> RESERVE <input type="checkbox"/> RETIRED <input type="checkbox"/> DEPENDENT (Complete Section 2 below) <input type="checkbox"/> AUXILIARY		I. UNIT NAME	J. BRANCH OF SERVICE
SECTION 2 - IDENTIFICATION OF SPONSOR (Complete only if injured person is a dependent; otherwise, leave blank)			
A. NAME (Last, First and Middle Initial)		B. SSAN	C. RANK/RATE D. WORK TELEPHONE <input type="checkbox"/> FTS <input type="checkbox"/> COMM
E. HOME ADDRESS (Include zip code)		F. HOME TELEPHONE	
G. STATUS OF SPONSOR <input type="checkbox"/> ACTIVE DUTY <input type="checkbox"/> RETIRED <input type="checkbox"/> RESERVED		H. UNIT NAME	I. BRANCH OF SERVICE
SECTION 3 - ACCIDENT DATA			
A. ACCIDENT INFORMATION (Include zip code with addresses): <input type="checkbox"/> AUTOMOBILE (city/state): <input type="checkbox"/> JOB RELATED (employers name/address): <input type="checkbox"/> PROPERTY RELATED (owners name/address):			B. DATE AND TIME
C. BRIEFLY DESCRIBE THE ACCIDENT (Include who caused the injury and how it happened):			
SECTION 4 - ATTORNEY INFORMATION			
A. NAME OF YOUR ATTORNEY		B. ADDRESS (Include zip code)	C. TELEPHONE NUMBER
SECTION 5 - AMBULANCE SERVICE			
A. NAME OF AMBULANCE SERVICE		B. ADDRESS (Include zip code)	C. TELEPHONE NUMBER
MAIL TO: Commandant (G-WRP-2) U.S. Coast Guard 2100 2nd St. S.W. Washington, DC 20593-0001	PRIVACY ACT STATEMENT Sections 2651-2563 of Title 42 to the U.S. Code authorize collection of this information. Furnishing the Social Security No. is empowered by Exec. Order 9397 and is mandatory to identify authorized beneficiaries. This information is principally used to document incidents that lead to injured party(ies) receiving medical care at the expense of the U.S. Coast Guard. Routine uses include lawful enforcement and investigations for recovery from third party liability. If the requested information is not furnished, recovery of Federal funds may be hampered, possibly limiting continued delivery of comprehensive health care.		

SECTION 6 - MOTOR VEHICLE ACCIDENT

(DATA PERTAINING TO VEHICLE IN WHICH YOU WERE DRIVING OR RIDING)

A. NAME OF DRIVER Military? <input type="checkbox"/> YES <input type="checkbox"/> NO	B. HOME ADDRESS (Include zip code)	C. WORK TELEPHONE <input type="checkbox"/> FTS <input type="checkbox"/> COMM
D. NAME OF OWNER Military? <input type="checkbox"/> YES <input type="checkbox"/> NO	E. YEAR/MAKE/MODEL OF AUTOMOBILE	F. LICENSE PLATE NUMBER
G. OWNER'S INSURANCE COMPANY AND POLICY NUMBER	H. ADDRESS (Include zip code)	I. TELEPHONE NUMBER
J. NAMES OF INJURED PASSENGER(S)	K. ADDRESS(ES) (Include zip code)	L. TELEPHONE NUMBER(S)

(DATA PERTAINING TO OTHER VEHICLE)

M. NAME OF DRIVER Military? <input type="checkbox"/> YES <input type="checkbox"/> NO	N. ADDRESS (Include zip code)	O. TELEPHONE NUMBER
P. NAME OF OWNER Military? <input type="checkbox"/> YES <input type="checkbox"/> NO	Q. YEAR/MAKE/MODEL OF AUTOMOBILE	R. LICENSE PLATE NUMBER
S. OWNER'S INSURANCE COMPANY AND POLICY NUMBER	T. ADDRESS (Include zip code)	U. TELEPHONE NUMBER

SECTION 7 - ALL OTHER ACCIDENTS

(DATA PERTAINING TO INSURANCE OTHER THAN AUTOMOBILE)

A. RESPONSIBLE PARTY'S INSURANCE COMPANY AND POLICY NUMBER	B. ADDRESS (Include zip code)	C. TELEPHONE NUMBER
D. TYPE OF INSURANCE <input type="checkbox"/> HOME OWNERS <input type="checkbox"/> PERSONAL MEDICAL INSURANCE <input type="checkbox"/> WORKERS COMPENSATION		
E. INJURED PARTY'S INSURANCE COMPANY AND POLICY NUMBER	F. ADDRESS (Include zip code)	G. TELEPHONE NUMBER
H. TYPE OF INSURANCE <input type="checkbox"/> HOME OWNERS <input type="checkbox"/> PERSONAL MEDICAL INSURANCE <input type="checkbox"/> WORKERS COMPENSATION		

SECTION 8 - MILITARY/CIVILIAN HOSPITALIZATION

A. NAME OF HOSPITAL(S)	B. ADDRESS(ES) (Include zip code)	C. DATE(S) OF TREATMENT FROM _____ TO _____	D. PAYMENT MADE BY: <input type="checkbox"/> SELF <input type="checkbox"/> INSURANCE <input type="checkbox"/> CHAMPUS
		FROM _____ TO _____	<input type="checkbox"/> SELF <input type="checkbox"/> INSURANCE <input type="checkbox"/> CHAMPUS

SECTION 9 - MILITARY/CIVILIAN DOCTORS/DENTISTS

A. NAME OF DOCTOR(S)	B. ADDRESS(ES) (Include zip code)	C. DATE(S) OF TREATMENT FROM _____ TO _____	D. PAYMENT MADE BY: <input type="checkbox"/> SELF <input type="checkbox"/> INSURANCE <input type="checkbox"/> CHAMPUS
		FROM _____ TO _____	<input type="checkbox"/> SELF <input type="checkbox"/> INSURANCE <input type="checkbox"/> CHAMPUS
		FROM _____ TO _____	<input type="checkbox"/> SELF <input type="checkbox"/> INSURANCE <input type="checkbox"/> CHAMPUS

E. IS TREATMENT COMPLETE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF NO, WHEN DO YOU EXPECT IT TO BE COMPLETE? _____
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